# AUTHORIZATION REQUEST

Purchase of Medical Care Services
DHHS – Controller's Office

***Read Instructions on Back***

1. Last Name First Name MI

2. Patient SS # ___ ___ ___ — ___ ___ — ___ ___ ___ ___

3. Date of Birth Month Day Year

4. Sex ☐ 1. Male ☐ 2. Female

5. Race ☐ 1. White ☐ 2. Black ☐ 3. American Indian ☐ 4. Asian ☐ 5. Native Hawaiian/Other Pacific Islander ☐ 6. Unknown

Ethnicity: Hispanic or Latino Origin? ☐ Yes ☐ No ☐ Unknown

6. Preferred Language: Select from the list on the back of this form.

| | | | | | |
|---|---|---|---|---|---|
| ☐ AR | ☐ CA | ☐ CH | ☐ EN | ☐ FR | ☐ FC |
| ☐ GE | ☐ GR | ☐ GU | ☐ HI | ☐ HM | ☐ HU |
| ☐ IT | ☐ JA | ☐ KO | ☐ LA | ☐ MI | ☐ MK |
| ☐ OT | ☐ PE | ☐ PO | ☐ PG | ☐ PC | ☐ RU |
| ☐ SC | ☐ SP | ☐ TA | ☐ TH | ☐ UR | ☐ VI |

7. County of Residence:

8. Address– Street or RFD

9. City State Zip Code

10. Telephone # Home Work

11. Name of Parent or Guardian Last First Middle

12. Program
**INFANT TODDLER**

13. POMCS Case Number

14. Name and Address of Hospital or Provider of Requested Service

Phone #:

15. Service is authorized for the following date range:

16. Diagnostic Code/Diagnosis:
Primary Secondary

17. (Required field) Complete for all ITP Requests
Assigned Sliding Fee Scale Percentage _____ %

18. Insurance or Third Party (DO NOT COMPLETE THIS SECTION FOR CC&E)
Does family carry health insurance on this child? ☐ Yes ☐ No
Did parents give permission for insurance to be billed? ☐ Yes ☐ No ☐ Not Applicable (If No or N/A, skip to Section 19 below.)

Does this policy cover this service? ☐ Yes ☐ No ☐ Unknown
Complete insurance information is required when applicable.
PRIMARY INSURANCE
Policy #: Claims Address:

Policyholder:

Insurance Phone #:

Does this policy cover this service? ☐ Yes ☐ No ☐ Unknown
Complete insurance information is required when applicable.
SECONDARY INSURANCE
Policy #: Claims Address:

Policyholder:

Insurance Phone #:

19. CHECK SERVICES REQUESTED

A. ☐ Audiology Services
B. ☐ Case Consultation and Education (Medicaid/non-Medicaid)
C. ☐ Developmental Evaluations
D. ☐ Family Counseling and Therapy Services
E. ☐ Nutrition Services
F. ☐ Occupational Therapy Services
G. ☐ Physical Therapy Services
H. ☐ Psychological Services
I. ☐ Social Work Services
J. ☐ Community Based Rehabilitative Services (CBRS)
K. ☐ Speech and Language Therapy Services
L. ☐ Targeted Case Management Services

20. Describe service requested. Enter the total number of units for the entire authorization period. Frequency per week or month may be entered. For Case Consultation and Education (CC&E), provider discipline **must** be indicated by checking the appropriate box to the right of the code in the table below.

Code For CC&E Discipline Only: Select one.
1 ☐ Community Based Rehabilitative Services (CBRS)
2 ☐ Speech/Language Provider
3 ☐ Physical Therapist
4 ☐ Occupational Therapist
5 ☐ Social Worker
6 ☐ Nutritionist/Registered Dietician
7 ☐ Psychologist
8 ☐ Audiologist
9 ☐ Registered Nurse

21. Enter names and addresses of individuals to whom a copy of an approved Authorization Reply should be sent, such as the Service Coordinator, ITP Supervisor, DSS Worker. **Do not include those listed in blocks 14 and 24.**

22A. Type or print Service Coordinator's name

22B. Service Coordinator's Signature

23. Signature of CDSA Financial Officer (or designee)

24. Name of Requesting CDSA (central office)
Financial Officer:
Address of Central CDSA Office:

Phone #: Date:



Print Reset

# INSTRUCTIONS

**PURPOSE**

This form is used to submit written authorizations for ITP funded services by the local Children's Developmental Services Agency [CDSA] and to provide a mechanism for reimbursement to Infant-Toddler Program [ITP] Providers.

To qualify for payment to the ITP Provider, the child must be referred to or eligible for the ITP. All authorizations originate through the CDSA. Designated staff at the CDSA must complete this Authorization Request form for each service, and it must be received by POMCS no later than 60 days after the first date of service within the authorization period. Processing time is reduced when this form is legible and all fields are complete.

**INSTRUCTIONS FOR COMPLETING CERTAIN ITEMS ON THE FORM:**

Items **1**-**11** – Enter complete, legible, and accurate information.

Item **6** – Select from one of the following languages (see table on right) and enter the two letter code in item 6 on the front of this form.

| | | |
|---|---|---|
| AR Arabic | HM Hmong | PO Polish |
| CA Cambodian | HU Hungarian | PG Portuguese |
| CH Chinese | IT Italian | PC PG Creole |
| EN English | JA Japanese | RU Russian |
| FR French | KO Korean | SC Serbo-Croatian |
| FC Fr Creole | LA Laotian | SP Spanish |
| GE German | MI Miao | TA Tagalong |
| GR Greek | MK Mon-Khmer | TH Thai |
| GU Gujarati | OT Other | UR Urdu |
| HI Hindi | PE Persian | VI Vietnamese |

Items **10**, **14**, **18**, and **24** – Always include area code when entering phone numbers.

Item **13** – Enter POMCS case number, if known.

Item **14** – Enter the ITP Provider Agency who will be providing the authorized service, their mailing address and phone number.

Item **15** – Enter the date range for the authorization period. This should correspond to the IFSP authorization period for the child. POMCS will not reimburse ITP Providers for services that exceed the parameters indicated in Item 15 and Item 20.

Item **16** – [Optional field] Enter ICD-9 code[s]. Diagnosis should correspond to the requested service.

Item **17** – Enter the assigned Sliding Fee Scale Percentage. This is a required field, so even if the family's assigned percentage is zero, enter the assigned percentage in the space provided.

Item **18** – This is a required field unless authorizing CC&E. If the answer to the first question is yes, then the next question must be answered. If the answer to the second question is yes, then the third question must be answered. If the service is covered by the insurance carrier, or if coverage is unknown, and if the family has given permission for their insurance company to be billed, then all the additional insurance information in this box must also be completed.

Item **19** – Check only one box per authorization form. Authorization forms with more than one box checked will be returned to the CDSA. **Note: For CC&E, a separate authorization will be needed for each provider discipline.**

Item **20** – The description entered in this section will be sent to the provider by POMCS. Frequency and the total number of weekly/monthly units should be described for clarity, but the TOTAL NUMBER OF UNITS PER AUTHORIZATION PERIOD IS ALSO REQUIRED. POMCS is not responsible for this calculation. The authorization period is the date range listed in Item 15. POMCS will not reimburse ITP Providers for services that exceed the parameters indicated in Item 15 and Item 20. All services must be addressed in terms of units. For CC&E, indicate which discipline CC&E is being authorized to cover by checking the appropriate box, and indicate the total number of units to be warranted for the authorization period.

Item **21** – Enter the name[s] and address[es] of anyone [**other than** the central CDSA office/address and the ITP Provider listed in Item 14] who should receive a copy of the approved authorization letter. [Examples: The Service Coordinator's name and address, the ITP Supervisor's name and address, DSS worker's name and address]. There is space for two entries in this section.

Item **22A** – Type or print the EI Service Coordinator's name here.

Item **22B** – Signature of the EI Service Coordinator must be entered here.

Item **23** – Signature of CDSA Financial Officer or designee must be entered here.

Item **24** – Enter your official CDSA central office name, the name of the Financial Officer, and your CDSA's central office mailing address and phone number, along with the date completed. [This information may be stamped or prewritten, but the date must be entered each time to reflect when the form was actually completed.]

**MAIL COMPLETED AUTHORIZATIONS TO:**

Purchase of Medical Care Services
DHHS-Office of the Controller
1904 Mail Service Center
Raleigh, North Carolina 27699-1904

Faxed authorizations are not given priority. CDSA Service Coordinators/Finance Officers should contact POMCS regarding the need to expedite a request.

**BILLING:** After a service has been authorized and provided, CMS-1500 claims should be submitted by the ITP Provider directly to:

POMCS Claims Unit
DHHS-Office of the Controller
1904 Mail Service Center
Raleigh, North Carolina 27699-1904

If there is other third party coverage and the family has given permission to bill third party insurance, an ITP Provider may have to wait up to six months to receive payment or denial before submitting a claim to be paid to POMCS. Claims must be received within one year after the date of service for an ITP Provider to be paid.

**HOW TO ORDER THIS FORM:** You may obtain this form by mailing a request to the above address or faxing your order to: 919/715-3848. Call 919/855-3672 to request a POMCS Order Form DHHS 3056-ITP.

WEBSITE: www.ncdhhs.gov/control/pomcs/pomcs.htm